Injection and Infusion Billing and Coding

WHITE PAPER

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FEATURES

Background

Injection and infusion rules tend to change often, and continuing education for nurses and other clinical and nonclinical staff members is necessary to help ensure that facilities receive the appropriate reimbursement for the services they provide.

The need for complete and accurate documentation can be difficult to convey to nursing staff members because of their focus on patient care. However, coding and billing for these services must also be areas of focus, as they too have an effect on patient care, as well as obvious ties to reimbursement. Multiple specific documentation components are necessary to enable billers and coders to accurately reflect these services, but each component is critical to ensuring that facilities receive the reimbursement they deserve.

The injection and infusion codes changed for 2009. The first three digits of each of the codes changed from 907 to 963; however, the AMA retained the final two digits (i.e., CPT codes 90760–90779 became codes 96360–96379 effective January 1).

Many of the infusion codes are time-based. Billers and coders should calculate infusion time according to the actual time over which the physician administers the infusion. Consider the following statement from the February *CPT Assistant*, Volume 19, Issue 2:

> *Services leading up to the infusion and following the infusion have been included in the infusion code services and are not reported separately. These services will include starting the IV and monitoring the patient post-infusion. Therefore, infusion time is calculated from the time the administration commences (i.e., the infusion starts dripping) to when it ends (i.e., the infusion stops dripping).*

When the healthcare professional administering the injection is continually present to observe the patient or when an infusion is 15 minutes or less, this is referred to as an IV or intra-arterial push. Infusions are primary to pushes, which are primary to injections, according to *CPT Assistant*. This holds true regardless of the clinical priority of a service.

The *CPT Manual* has broken the injection and infusion codes into three sections:

- Hydration services
- Therapeutic, prophylactic, and diagnostic services
- Chemotherapy services

Coders must follow a hierarchy when choosing an initial code to report when a patient receives multiple services from multiple sections: Chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services, and these services are primary to hydration services, according to *CPT Assistant*.

Have a knowledgeable coder review the codes selected any time a physician or other clinical staff member sticks a patient.

Coding for hydration and injection and infusion services is complex. Have a knowledgeable coder review the codes selected any time a physician or other clinical staff member sticks a patient. The coder should verify that the documentation identifies:

- The drug or substance provided
- The route (e.g., injection, push, infusion) into the patient
- The length of time for infusions, according to start and stop times
- The diagnosis for the service
- Only medically necessary services

Missing these items may mean your facility loses out on significant reimbursement.

Hydration services

When a patient is dehydrated and the treatment provided is hydration, hydration codes (CPT codes 96360 and 96361) come into play. Never use these codes to report infusion of drugs or other substances; the only purpose of hydration codes is to report the hydration to a patient. Hydration IV infusions consist of prepackaged fluid and electrolytes.

There are two codes for hydration. CPT code 96360, IV infusion, is for the initial 31 minutes to one hour of hydration. Code 96361 is for each additional hour of hydration provided when a patient receives more than 30 minutes of hydration beyond each hour increment. (***Note:*** Do not report 30 minutes or less of hydration.)

In other words, when a patient receives 45, 60, or even 90 minutes of hydration, report code 96360. However, when a patient receives more than 90 minutes, code 96361 is reportable in addition to 96360. Report code 96361 as necessary to account for all of the additional hours of hydration provided. For example, when four hours of hydration are provided, report codes 96360, 96361x3.

There is a significant positive change in the payment rate for hydration this year. For code 96360 (paid by APC 438), the 2009 payment rate is $73.67. For code 96361 (paid by APC 436), the 2009 payment rate is $24.89.

Therapeutic, prophylactic, and diagnostic injections and infusions

Therapeutic, prophylactic, and diagnostic injections and infusions serve to administer substances or drugs (e.g., antibiotics) to patients. These services are not for hydration, chemotherapy, or other highly complex drug or biologic agent administration. When a physician uses fluid to administer the drug(s), the administration of the fluid is considered part of the therapeutic, prophylactic, or diagnostic service (i.e., not separately reportable). Hydration is not reportable in addition to therapeutic, prophylactic, or diagnostic injections and infusions.

The *CPT Manual* organizes the therapeutic, prophylactic, and diagnostic injection and infusion codes according to the method by which the patient receives the service:

- Codes 96365–96368 for IV infusion
- Codes 96369–96371 for subcutaneous infusion
- Codes 96372–96376 for injections

Multiple add-on codes may be necessary to convey sequential or concurrent injections and infusions.

In addition, note the presence of add-on codes in this section. Multiple add-on codes may be necessary to convey sequential or concurrent injections and infusions. However, only one initial service code is reportable unless multiple IV sites are required. The *2009 CPT Manual* provides important information regarding the use of these add-on codes.

Consider the following example found in the February *CPT Assistant*, Volume 19, Issue 2:

> ***Q:*** ***Would codes 96365 and 96368 be reported in the following scenario, regardless of how long drug B was infused, following the 30 minutes of concurrent infusion? The patient is seen in the outpatient clinic for drug infusion. Drug A is administered from 6 a.m. to 7:30 a.m. Drug B is administered through the same intravenous line from 7 a.m. to 4 p.m. Upon review of the infusion interval, there are only 30 minutes when both drugs were infused concurrently.***
>
> ***A:*** *Yes. Codes 96365 and 96368 could both be reported, but reporting codes 96365 and 96367 more accurately reflects the service. Code 96365, Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour, should be reported for the 1.5-hour infusion from 6 a.m. to 7:30 a.m. Code 96366, Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure), is not reportable since the infusion interval did not exceed 30 minutes beyond the 1-hour increment (code 96365). This usage is stated in the parenthetical instruction following code 96366.*

Note that CPT codes 96365–96376 only account for the administration of the injection or infusion, not for the drug or substance infused. For example,

when a patient receives 2 mg IM of Decaject, report the drug with J1100x2 and the administration of the drug with CPT 96372.

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Coders and billers need to remember to report the substance or drug administered, as well as the administration code. The cost of drugs can be significant, and facilities risk losing reimbursement for these costs when billers and coders neglect to report these codes.

For 2009, the therapeutic, prophylactic, and diagnostic injection and infusion payment rates are as follows:

- Code 96365 (paid by APC 439): $128.62
- Codes 96366, 96371, and 96372 (paid by APC 436): $24.89
- Codes 96367, 96370, and 96373–96375 (paid by APC 437): $36.13
- Code 96369 (paid by APC 438): $73.67
- Add-on codes 96368 and 96376 are packaged, and there is no separate APC payment

Chemotherapy and other highly complex drug administration

Chemotherapy and other complex drug administration services are typically more complicated than injection and infusion services. These services generally require more monitoring (e.g., blood pressure), and the risk of adverse patient reactions is often much higher. Significant training is necessary for clinical staff members who administer chemotherapy or other highly complex drugs. For example, some drugs can cause problems when infused into the patient too quickly. As a result, clinical staff members who provide the services must be highly skilled. There is also a much higher need for physician communication or supervision.

In addition, chemotherapy drugs are often very dangerous. Nurses need to mix together different agents under a hood. Accidental exposure to the substances while the drugs are prepared or provided could cause nursing staff members to become ill. And if substances are mixed incorrectly, it could cause severe problems for the patient.

Report CPT codes 96401–96549 for the administration of nonradionuclide antineoplastic drugs and agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for autoimmune conditions) or to substances such as certain monoclonal antibody agents and other biologic response modifiers. More specifically, the codes in this section of the *CPT Manual* are as follows:

- Code 96401: nonhormonal chemotherapy
- Code 96402: hormonal chemotherapy
- Codes 96405–96406: intralesional chemotherapy
- Codes 96409–96411: chemotherapy administration via IV push
- Codes 96413–96417: time-based chemotherapy administration via IV infusion

- Codes 96420–96425: time-based intra-arterial chemotherapy administration
- Codes 96440–96549: other injections and infusion services

As with therapeutic, prophylactic, and diagnostic injections and infusions, be sure to report the drug in addition to the administration code. Fluid used in chemotherapy or other highly complex drug administration is considered incidental hydration and is not separately reportable.

Coding and charge capture process

Each department should customize its charge slip to list all of the drugs and services it provides—but only those it provides.

It is advisable to create an encounter form (i.e., charge slip or ticket) to capture services provided and drugs used. The charge slip should be easy for nurses to use. Each department should customize its charge slip to list all of the drugs and services it provides—but only those it provides. For example, certain departments may only use certain drugs or may perform pushes but not infusions. Take these factors into consideration to create effective charge slips. (See the sample charge slip on p. 6.)

Nurse education on injection and infusion documentation requirements is critical. Coders and billers need to bill for the majority of these services based on nursing documentation. Nurses need to accurately capture the following information:

- Drug(s) provided and the quantities used
- Start and stop times of the infusions
- Why the patient is receiving the injection or infusion that day

Capturing this information will enable coders and billers to assign appropriate CPT, HCPCS Level II, and ICD-9-CM codes.

Physician education is also necessary so when nurses begin treatment, they know why they are doing so. For example, a nurse documents that a patient receives treatment for anemia. However, the physician neglects to document that the patient has aplastic anemia. The facility may not receive reimbursement if a local coverage determination says anemia is not a payable diagnosis, even though aplastic anemia is. It is easy to see the importance of educating physicians, nurses, and other clinical staff members on providing detailed documentation for the diagnosis they are treating—it may mean the difference between being paid or not.

In addition, understanding the administrative flow after an injection or infusion service is complete will help ensure timely and accurate reimbursement. Look for holes; once the patient leaves after receiving an injection or infusion, what happens?

Filling in the gaps and streamlining the process will ensure that nurses document and fill out charge slips and submit them to the coding department in a timely fashion. Monitor the timeliness of the process from when nurses

DRUG CHARGE TICKET

PATIENT LABEL

DIAGNOSIS

CHEMOTHERAPY DRUGS		
_____	J9264	ABRAXAN, per 1 mg
_____	J9000	ADRIAMYCIN, per 10 mg
_____	J9305	ALIMTA, per 10 mg
_____	J9017	ARSENIC TRIOXIDE, per 1 mg
_____	J9035	AVASTIN, per 10 mg
_____	J9050	BCNU, per 100 mg
_____	J9040	BLEOMYCIN, per 15 U
_____	J9010	CAMPATH, per 10 mg
_____	J9045	CARBOPLATIN, per 50 mg
_____	J9060	CISPLATIN, per 10 mg
_____	J9120	COSMEGEN, per 0.5 mg
_____	J9093	CYTOXAN, per 100 mg
_____	J0894	DACOGEN, per 1 mg
_____	J9098	DEPOCYT, per 10 mg
_____	J9001	DOXIL, per 10 mg
_____	J9130	DTIC-DOME, per 100 mg
_____	J9055	ERBITUX, per 10 mg
_____	J9395	FASLODEX, per 25 mg
_____	J9185	FLUDARA, per 50 mg
_____	J9201	GEMZAR, per 200 mg
_____	J9355	HERCEPTIN, per 10 mg
_____	J9214	INTRON A, per 1 million units
_____	J9206	IRINOTECAN, per 20 mg
_____	J9207	IXEMPRA, per 1 mg
_____	J9217	LUPRON, per 7.5 mg
_____	J9209	MESNA, per 200 mg
_____	J9250	METHOTREXATE, per 5 mg
_____	J9390	NAVELBINE, per 10 mg
_____	J9230	NITROGEN MUSTARD, per 10 mg
_____	J9293	NOVANTRONE, per 5 mg
_____	J9370	ONCOVIN, per 1 mg
_____	J9263	OXALIPLATIN, per 0.5 mg
_____	J9310	RITUXAN, per 100 mg
_____	J9265	TAXOL, per 30 mg
_____	J9170	TAXOTERE, per 20 mg
_____	J9350	TOPOTECAN, per 4 mg
_____	J9330	TORISEL, per 1 mg
_____	J9360	VELBAN, per 1 mg
_____	J9041	VELCADE, per 0.1 mg
_____	J9025	VIDAZA, per 1 mg
_____	J9181	ETOPOSIDE, per 10 mg
_____	J9202	ZOLADEX, per 3.6 mg
CHEMO INFUSION		
_____	96413	CHEMO INFUSION, initial hr
_____	96415	CHEMO INFUSION, each add'l hr
_____	96409	CHEMO IVP
_____	96411	CHEMO IVP, each add'l

TX/PROPHYL/DX DRUGS		
_____	J2469	ALOXI, per 25 mg
_____	Q0180	ANZEMET, PO, per 100 mg
_____	J0881	ARANESP, per 1 mcg, TX DAY
_____	J2430	AREDIA, per 30 mg
_____	J2060	ATIVAN, per 2 mg
_____	J0460	ATROPINE, per 0.3 mg
_____	J3420	B-12, up to 1,000 mcg
_____	J1200	BENADRYL, up to 50 mg
_____	J0610	CALCIUM GLUCONATE, per 10 ml
_____	J0692	CEFEPIME, per 500 mg
_____	J2597	DDAVP, per 1 mcg
_____	J1100	DECADRON, per 1 mg
_____	J1170	DILAUDID, up to 4 mg
_____	J0885	EPOGEN, per 1,000 units
_____	J7192	FACTOR 8 recombinant, per IU
_____	J7193	FACTOR 9, per IU
_____	J1644	HEPARIN, per 1,000 units
_____	J1720	HYDROCORTISONE, per 100 mg
_____	J1815	INSULIN, per 5 units
_____	J3480	KCL, per 2 meq
_____	J0641	LEVOLEUCOVORIN, per 0.5 mg
_____	J3475	MAGNESIUM, per 500 mg
_____	J2150	MANNITOL 25% in 50 ml
_____	J2175	MEPERIDINE, per 100 mg
_____	J2270	MOPHINE, up to 10 mg
_____	J1440	NEUPOGEN, per 300 mcg
_____	J2353	SANDOSTATIN LAR, per 1 mg
_____	J2930	SOLU-MEDROL, up to 125 mg
_____	J2780	ZANTAC, per 25 mg
_____	J2405	ZOFRAN, per 1 mg
_____	Q0179	ZOFRAN, PO, per 8 mg
_____	J3487	ZOMETA, per 1 mg
NON-CHEMO INJECTIONS		
_____	96372	IM/SQ ADMIN NON-CHEMO DAY
SUPPLIES		
_____	J7070	D5W SOLUTION
_____	A4212	HUBER NEEDLE
_____	A4222	TAXOL TUBING
_____	J7040	NORMAL SALINE
TX/PROPHY/DX INFUSION/IVP (NON-CHEMO)		
_____	96365	IV INFUSION, 1st hr non-chemo
_____	96366	IV INFUSION, add'l hr non-chemo
_____	96367	IV INFUSION, add'l seq to 1 hr
_____	96374	IVP initial non-chemo
_____	96375	IVP each add'l non-chemo

Source: HCPro, Inc.

dictate their charts after seeing a patient to the time billers and coders verify the charges the nurse selected or code the services the nurse provided and enter the charges into the billing system.

Routine feedback between coding staff members, nurses, and physicians is necessary for the process to work. If there is a nurse who continually misses drugs or neglects to capture stop times, consistent feedback can serve as a reminder to keep him or her from doing so.

Injection and infusion policies change frequently; a drug used for a treatment today, tomorrow may only be payable after trying three other regimens first.

Injection and infusion policies change frequently; a drug used for a treatment today, tomorrow may only be payable after trying three other regimens first. Frequent communication and continual education is necessary to keep all staff members updated and current.

In addition, examine the cost of drugs that your facility buys and the amount it bills for those drugs. If you find that you spend more to put the drugs on your shelves than you receive in reimbursement after using them, try to determine where and why it occurs.

Often, a multitude of reasons factor in. Consider the following possible problems:

- The charge slip doesn't list all of the services or drugs that you provide
- Nurses aren't capturing all of the services they provide
- There is suboptimal documentation, so coders aren't reporting all possible codes
- There is a process flow problem
- Coding staff members aren't well versed in coding for hydration or injection and infusion therapy

It is imperative for facilities to review drug purchasing versus billing at least monthly, especially if you provide these services in high volume. Drug costs are too high not to.

Finally, after billing out charges, don't sit back and wait for the money to come in. Take the time to review the charges. Use a reconciliation process to help find and challenge underpaid charges or those inappropriately denied.

Payment validation

Once you have educated your physicians, nurses, and coding staff members on injection and infusion coding and billing, consider putting into place a payment validation process. This may be a manual process or one that you perform via your facility's billing system. The method depends on the size of your facility and abilities of your billing system.

To validate payments, pull a range of sample cases (including several high-dollar claims) on a monthly basis. Allow time for payments to post in the

billing system before reviewing the claims; reviews could be a couple months out from the actual service date. Review the submitted charges for payment billed versus payment received. Verify payments according to the fee schedule for the selected payer. Flag those that don't match for further review and possible follow-up. Address any valid underpayments with the payer.

Many billing systems are sophisticated enough to perform this function electronically and generate a payment validation report. Some billing systems allow for greater specificity in terms of reporting. You may be able to run reports by payer, cost center, procedure code, and date of service. You may also be able to sort by highest dollar.

In addition, most billing systems have the ability to flag accounts when your facility doesn't receive the reimbursement the billing system anticipates. This allows you to identify when your facility did not receive reimbursement for certain drugs with certain diagnoses for particular treatment options. Without a thorough examination and review of the revenue cycle process for infusions and injections, some of these items may go undiscovered.

Performing payment validation not only ensures that your facility receives the payments to which it is entitled, but it can also help identify trends.

Performing payment validation not only ensures that your facility receives the payments to which it is entitled, but it can also help identify trends when payers are not reimbursing or are adjusting the amount of reimbursement for particular drugs or services. If these trends remain unidentified, your facility may quickly experience a loss of revenue. ■